
| | | | |
|-----------------------------|---|------------------------|--|
| State: | Arkansas | Filing Company: | Standard Life and Accident Insurance Company |
| TOI/Sub-TOI: | H02G Group Health - Accident Only/H02G.000 Health - Accident Only | | |
| Product Name: | Group Supplemental Accident revised Application | | |
| Project Name/Number: | SL-GAP-APP-2012 /SL-GAP-APP-2012 | | |

Filing at a Glance

| | |
|----------------------|---|
| Company: | Standard Life and Accident Insurance Company |
| Product Name: | Group Supplemental Accident revised Application |
| State: | Arkansas |
| TOI: | H02G Group Health - Accident Only |
| Sub-TOI: | H02G.000 Health - Accident Only |
| Filing Type: | Form |
| Date Submitted: | 08/01/2012 |
| SERFF Tr Num: | AMFT-128435381 |
| SERFF Status: | Closed-Approved-Closed |
| State Tr Num: | |
| State Status: | Approved-Closed |
| Co Tr Num: | SL-GAP-APP-2012 |
| Implementation | On Approval |
| Date Requested: | |
| Author(s): | Rebecca Ewing |
| Reviewer(s): | Rosalind Minor (primary) |
| Disposition Date: | 08/02/2012 |
| Disposition Status: | Approved-Closed |
| Implementation Date: | |

State Filing Description:

State: Arkansas **Filing Company:** Standard Life and Accident Insurance Company
TOI/Sub-TOI: H02G Group Health - Accident Only/H02G.000 Health - Accident Only
Product Name: Group Supplemental Accident revised Application
Project Name/Number: SL-GAP-APP-2012 /SL-GAP-APP-2012

General Information

Project Name: SL-GAP-APP-2012 Status of Filing in Domicile: Pending
Project Number: SL-GAP-APP-2012 Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small
Group Market Type: Employer Overall Rate Impact:
Filing Status Changed: 08/02/2012
State Status Changed: 08/02/2012 Deemer Date:
Created By: Rebecca Ewing Submitted By: Rebecca Ewing
Corresponding Filing Tracking Number:

Filing Description:

Re: Standard Life and Accident Insurance Company NAIC # 86355
Form SL-GAP-APP-2012

Dear Sir/Madam:

Please find enclosed for your review and approval the following form:

Form Number: SL-GAP-APP-2012
Description - Application for Group Accident Limited Benefit Insurance

This application will replace form number SLIC-GAP Grp App, Application for Group Accident. This application was approved as part SLIC-GAP-P (0405), et al which was previously approved by your Department on 6/27/05.

The following areas of this application have been revised: Company address; minor formatting, Eligibility, Insurance Applied For, Plan Design Selection, Payroll and Billing Information and Agreements, Representations and Understanding.

If you have any questions, please call me at (972) 850-3272 or email me at rewing@lewisellis.com.

Sincerely,
Rebecca Ewing, FLMI, HIA, ACS, ACP
Compliance Consultant
Lewis & Ellis, Inc. – Actuaries & Consultants

Company and Contact

Filing Contact Information

Rebecca Ewing, Compliance Consultant rewing@lewisellis.com
2929 N. Central Expy., Suite 201 972-850-3272 [Phone]
P. O. Box 851857 972-850-3273 [FAX]
Richardson, TX 75085

State: Arkansas **Filing Company:** Standard Life and Accident Insurance Company
TOI/Sub-TOI: H02G Group Health - Accident Only/H02G.000 Health - Accident Only
Product Name: Group Supplemental Accident revised Application
Project Name/Number: SL-GAP-APP-2012 /SL-GAP-APP-2012

Filing Company Information

| | | |
|--|-------------------------|---------------------------------|
| Standard Life and Accident Insurance Company | CoCode: 86355 | State of Domicile: Oklahoma |
| One Moody Plaza | Group Code: | Company Type: Insurance Company |
| Galveston, TX 77550-7999 | Group Name: | State ID Number: |
| (409) 766-6959 ext. [Phone] | FEIN Number: 73-0994234 | |

Filing Fees

Fee Required? Yes
Fee Amount: \$25.00
Retaliatory? Yes
Fee Explanation: Per Oklahoma requirements.
Per Company: No

| Company | Amount | Date Processed | Transaction # |
|--|---------|----------------|---------------|
| Standard Life and Accident Insurance Company | \$25.00 | 08/01/2012 | 61342667 |
| Standard Life and Accident Insurance Company | \$25.00 | 08/02/2012 | 61379672 |

| | | | |
|-----------------------------|---|------------------------|--|
| State: | Arkansas | Filing Company: | Standard Life and Accident Insurance Company |
| TOI/Sub-TOI: | H02G Group Health - Accident Only/H02G.000 Health - Accident Only | | |
| Product Name: | Group Supplemental Accident revised Application | | |
| Project Name/Number: | SL-GAP-APP-2012 /SL-GAP-APP-2012 | | |

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 08/02/2012 | 08/02/2012 |

Objection Letters and Response Letters

Objection Letters

| Status | Created By | Created On | Date Submitted |
|---------------------------|----------------|------------|----------------|
| Pending Industry Response | Rosalind Minor | 08/02/2012 | 08/02/2012 |

Response Letters

| Responded By | Created On | Date Submitted |
|---------------|------------|----------------|
| Rebecca Ewing | 08/02/2012 | 08/02/2012 |

| | | | |
|-----------------------------|---|------------------------|--|
| State: | Arkansas | Filing Company: | Standard Life and Accident Insurance Company |
| TOI/Sub-TOI: | H02G Group Health - Accident Only/H02G.000 Health - Accident Only | | |
| Product Name: | Group Supplemental Accident revised Application | | |
| Project Name/Number: | SL-GAP-APP-2012 /SL-GAP-APP-2012 | | |

Disposition

Disposition Date: 08/02/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|--|----------------------|---------------|
| Supporting Document | Flesch Certification | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | Authorization | Approved-Closed | Yes |
| Form | Application for Group Accident Limited Benefit Insurance | Approved-Closed | Yes |

| | | | |
|-----------------------------|---|------------------------|--|
| State: | Arkansas | Filing Company: | Standard Life and Accident Insurance Company |
| TOI/Sub-TOI: | H02G Group Health - Accident Only/H02G.000 Health - Accident Only | | |
| Product Name: | Group Supplemental Accident revised Application | | |
| Project Name/Number: | SL-GAP-APP-2012 /SL-GAP-APP-2012 | | |

Objection Letter

| | |
|-------------------------|---------------------------|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 08/02/2012 |
| Submitted Date | 08/02/2012 |
| Respond By Date | 09/02/2012 |

Dear Rebecca Ewing,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Application for Group Accident Limited Benefit Insurance, SL-GAP-APP-2012 (Form)

Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$50.00. Please submit an additional \$25.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

| | | | |
|-----------------------------|---|------------------------|--|
| State: | Arkansas | Filing Company: | Standard Life and Accident Insurance Company |
| TOI/Sub-TOI: | H02G Group Health - Accident Only/H02G.000 Health - Accident Only | | |
| Product Name: | Group Supplemental Accident revised Application | | |
| Project Name/Number: | SL-GAP-APP-2012 /SL-GAP-APP-2012 | | |

Response Letter

| | |
|------------------------|--------------------|
| Response Letter Status | Submitted to State |
| Response Letter Date | 08/02/2012 |
| Submitted Date | 08/02/2012 |

Dear Rosalind Minor,

Introduction:

Response 1

Comments:

An additional filing fee of \$25 has been submitted per your request. Thank you.

Related Objection 1

Applies To:

- Application for Group Accident Limited Benefit Insurance, SL-GAP-APP-2012 (Form)

Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$50.00. Please submit an additional \$25.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,

Rebecca Ewing

| | | | |
|-----------------------------|---|------------------------|--|
| State: | Arkansas | Filing Company: | Standard Life and Accident Insurance Company |
| TOI/Sub-TOI: | H02G Group Health - Accident Only/H02G.000 Health - Accident Only | | |
| Product Name: | Group Supplemental Accident revised Application | | |
| Project Name/Number: | SL-GAP-APP-2012 /SL-GAP-APP-2012 | | |

Form Schedule

| Lead Form Number: SL-GAP-APP-2012 | | | | | | | |
|-----------------------------------|-------------------------------|-----------------|-----------|--|------------------------------|-------------------|---------------------|
| Item No. | Schedule Item Status | Form Number | Form Type | Form Name | Action/ Action Specific Data | Readability Score | Attachments |
| 1 | Approved-Closed 08/02/2012 | SL-GAP-APP-2012 | AEF | Application for Group Accident Limited Benefit Insurance | Initial: | 52.900 | SL-GAP-APP-2012.pdf |

Form Type Legend:

| | | | |
|-------------|---|-------------|--|
| ADV | Advertising | AEF | Application/Enrollment Form |
| CER | Certificate | CERA | Certificate Amendment, Insert Page, Endorsement or Rider |
| DDP | Data/Declaration Pages | FND | Funding Agreement (Annuity, Individual and Group) |
| MTX | Matrix | NOC | Notice of Coverage |
| OTH | Other | OUT | Outline of Coverage |
| PJK | Policy Jacket | POL | Policy/Contract/Fraternal Certificate |
| POLA | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | SCH | Schedule Pages |

**Application for Group Accident Limited Benefit Insurance to:
Standard Life and Accident Insurance Company**

**Administrative Office:
5722 I-55 North Frontage Road • Jackson, MS 39211
or P.O. Box 14067 Jackson, MS 39236**

The Information provided by the Applicant in this Application will be the basis on which any insurance is issued. Incorrect information could void Insurance

| | | | |
|--|-----|---|-----|
| Legal Name of Employer (include d/b/a): | | Employer Identification Number | |
| Principal Business or Activity | | SIC Code | |
| Physical Address: (Street Number and Name) | | Billing Address: (If bill is to be split and sent to more than one billing address please indicate here and give addresses on an attached sheet.) | |
| City | | City | |
| State | ZIP | State | ZIP |

| | |
|---------------------------|-------------------------|
| Executive Contact Person: | Billing Contact Person: |
| Title: | Title: |
| Telephone: | Telephone: |
| Email Address: | Email Address: |
| Fax Number | Fax Number |

Employer's Major Medical or Comprehensive Plan Data

| |
|--|
| Major Medical Plan Carrier _____ |
| Major Medical Deductible Amount \$_____ |
| Major Medical Coinsurance ____ to Maximum Out of pocket (Coinsurance Limit) Amount \$ ____ |
| Are Major Medical Deductibles & Coinsurance per Plan Year or per Calendar Year? _____ |
| Major Medical Plan Anniversary Date _____ |
| Number of Covered: Employees _____ Dependent Spouses _____ Dependent Children _____ |

Eligibility

Eligible Person as used in the Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:

Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee)

[All active full time employees working 18 hours or more per week and who are under the age seventy will be eligible for coverage. Each insured will be eligible for Dependent coverage on the later of the following dates:

1. The day the insured becomes eligible for insurance; or
2. The day the Insured acquires his or her first dependent]

Eligible Person - If employer participates in paying the premiums

1. [An employee of the Policyholder who is insured by the employer's major medical plan;
2. An employee's dependent spouse or unmarried dependent children who were insured by the employer's major medical plan.] Eligible new employees or dependents may be added subject to the terms of the Policy.

Eligibility/Waiting Period (REQUIRED Select one) : ☐ 1st of month following ____ days;
☐ 1st of month following date of hire; ☐ Date of hire; or ☐ Day following completion of ____ days

{Eligible Classes: _____}

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the Termination of Coverage Provisions of the Policy.

Insurance Applied For

Employer Contribution {Premium Saver Plan} ☐ {HSA Saver Plan} ☐ {Med Bridge Plus Plan} ☐
{Accident Plan} ☐

Voluntary (Employee Paid Plans) ☐ {Med Bridge Plus Plan} ☐

Requested Effective Date _____

Employer will pay _____% or \$_____ of Employee Costs and _____% or \$_____ of Dependent Costs

{Important Note: All persons (100 % participation) insured by the Employer's Major Medical or Comprehensive Health Plan must be covered on Employer Contribution plans listed above.

Plan Design Selection

ATTACH FLIER OR PROPOSAL THAT DESCRIBES THE SPECIFIC BENEFITS

Applicable to {all} {Accident}{Sickness}{Inpatient}{and}{Outpatient} Benefits {Only}

Maximum Total Benefit Amount \$ _____

Per Year Benefit Maximum Basis:

☐ Plan Year

☐ Calendar Year

Comments _____

This Section for Office Use Only

ACCIDENT BENEFIT

{Co-payment Amount \$_____} {Per visit}

Maximum Benefit Amount All Covered Facilities per Year: \$_____

Maximum Benefit Amount for In-Hospital Confinement per Year \$ N/A

Maximum Benefit Amount All Covered Outpatient Facilities per Year: \$_____

OPTIONAL RIDERS

{Sickness Benefit Rider:} {☐ Yes ☐ No}

{Co-payment Amount \$_____} {Per visit}

{Maximum Benefit Amount All Covered Facilities per Year: \$_____}

{Maximum Benefit Amount for In-Hospital Confinement per Year \$ _____}

{Maximum Benefit Amount All Covered Outpatient Facilities per Year: \$_____}

{Hospital Indemnity Sickness Benefit Rider} {☐ Yes ☐ No}

{Outpatient Physicians Expense Rider} {☐ Yes ☐ No}

{Ambulance Benefit Rider} {☐ Yes ☐ No}

{Generic Outpatient Prescription Drug Rider} {☐ Yes ☐ No}

{Brand {and Generic} Prescription Drug Rider} {☐ Yes ☐ No}

{Outpatient Physical and Wellness Examination Rider} {☐ Yes ☐ No}

{Outpatient Diagnostic Test and Lab Rider} {☐ Yes ☐ No}

{Allied Services Rider} {☐ Yes ☐ No}

{Prior Plan Deductible Credit Rider} {☐ Yes ☐ No}

Policy/Certificate Delivery

Send Policy & Certificate to? ☐ Agent ☐ Employer

Payroll and Billing Information

{Billing is alphabetical -12 monthly Premiums}

Effective date can be {the 1st or the 15th of the month}

Make check payable to Standard Life and Accident Insurance Company.
\$_____ Amount of Attached Check.

ALL PREMIUMS ARE PAYABLE IN ADVANCE. THE FIRST PREMIUM MUST BE PAID PRIOR TO THE EFFECTIVE DATE OF INSURANCE.

Agreements, Representations and Understanding

I represent that all statements made herein are complete and true as of the date I signed this Application, and I understand that Standard Life and Accident Insurance Company (SLIC) will rely on these statements and this information as the basis for approving this Application.

I understand that the Group Accident Insurance Policy for which I have applied is a limited benefit Policy that pays only the benefits selected and set forth in the Policy itself. Our agent has explained the Policy's limitations and exclusions, if any.

I understand that only those employees and dependents covered under our company's major medical or comprehensive health plan are eligible for coverage.

Check One _____

{I **represent** that {100%} of eligible employees and dependents will be enrolled in the plan}. ☐

{I **represent** that this plan will be offered on a voluntary basis} ☐

I understand that coverage is effective when: a) the Policy is issued by SLIC; b) the Policy is received and accepted by the Policyholder; c) the full first premium is paid and accepted by SLIC.

{We agree} to make any necessary payroll deductions for any employee's share of the cost of this insurance and to remit the total premium for all insurance as premiums become due. We request that the Administrator bill our share of the premiums and any applicable administrative fee due under the insurance Policy issued.}

I understand that the Policyholder or SLIC may terminate the Policy and any Rider(s) on any premium due date by giving at least {90} days written notice to the other party. The Policyholder is responsible for notifying the Insureds of the termination or non-renewal of the Policy.

I understand that SLIC and the Policyholder may agree to amend the Policy at any time without the consent of any employee or other person.

I represent that the information herein is true and complete, as of the date I signed this Application, and that I have read and understand this form.

{I acknowledge and understand} that any misrepresentation on this Application by my agent or me may result in the cancellation or rescission of any Policy issued based on this Application.}

{I hereby represent that I have reviewed the fraud warning notice (if applicable) included with this Application for the Policyholder's state of domicile.}

On behalf of the Employer, this Application for Group Insurance is signed by

X _____ Print Name _____

Official Title _____ this _____ day of _____

Agent Name (print) _____ Signature _____

| {FRAUD WARNING NOTICE} | |
|---|---|
| {For residents of all states (except the following)} | {Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.} |
| {Arkansas} | {Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.} |
| {Colorado} | {It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.} |
| {District of Columbia} | {Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.} |
| {Florida} | {Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.} |
| {Kentucky} | {Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.} |
| {Louisiana} | {Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.} |
| {Maine} | {It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.} |
| {Nebraska} | {Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.} |
| {New Jersey} | {Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.} |
| {New Mexico} | {Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.} |
| {Pennsylvania} | {Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.} |
| {Tennessee} | {It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.}} |

| | | | |
|-----------------------------|---|------------------------|--|
| State: | Arkansas | Filing Company: | Standard Life and Accident Insurance Company |
| TOI/Sub-TOI: | H02G Group Health - Accident Only/H02G.000 Health - Accident Only | | |
| Product Name: | Group Supplemental Accident revised Application | | |
| Project Name/Number: | SL-GAP-APP-2012 /SL-GAP-APP-2012 | | |

Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|----------------------|-----------------|--------------|
| Satisfied - Item: | Flesch Certification | Approved-Closed | 08/02/2012 |
| Comments: | | | |
| Attachment(s): | | | |
| Rev-GAP App- readability cert-SLAICO AR.pdf | | | |

| | | Item Status: | Status Date: |
|------------------|-----------------------|-----------------|--------------|
| Bypassed - Item: | Application | Approved-Closed | 08/02/2012 |
| Bypass Reason: | See Form Schedule tab | | |
| Comments: | | | |

| | | Item Status: | Status Date: |
|--------------------------|---------------|-----------------|--------------|
| Satisfied - Item: | Authorization | Approved-Closed | 08/02/2012 |
| Comments: | | | |
| Attachment(s): | | | |
| SLAICO-Authorization.pdf | | | |

June 7, 2012

State of Arkansas

Re: Readability Certification for Policy Forms
 Standard Life and Accident Insurance Company

To Whom It May Concern:

The following form(s) have been tested for readability and meet the minimum reading ease score as required by the state of Arkansas.

| Form Number | Flesch Score |
|-------------------|--------------|
| SLIC-GAP-APP-2012 | 52.9 |
| | |



Rebecca Ewing, FLMI, HIA ACS, ACP
Compliance Consultant
Lewis & Ellis, Inc. – Actuaries & Consultants

Date: June 7, 2012



STANDARD LIFE AND ACCIDENT INSURANCE COMPANY

STEVEN H. SCHOUWEILER, FLMI

EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER

2450 South Shore Blvd. Suite 500, League City, Texas, 77573

BUS: (281) 538-3775 FAX: (281) 538-3393 EMAIL: steve.schouweiler@anico.com

July 10, 2009

David White
President
Morgan White Group
P.O. Box 14067
Jackson, MS 39236-4607

Lewis & Ellis, Inc.
2929 N. Central Expressway
Suite 200
P.O. Box 851857
Richardson, TX 75085-1857

Re: Standard Life and Accident Insurance Company

To Whom It May Concern:

Morgan White is hereby authorized to retain Lewis & Ellis, Inc. for state filings and approvals of insurance forms/rates/products on behalf of Standard Life and Accident Insurance Company, a subsidiary of American National Insurance Company. This authorization for filings on behalf of Standard Life and Accident Insurance Company shall be for products exclusive to Morgan White.

This authorization is to be effective until revoked in writing by an authorized representative of Standard Life and Accident Insurance Company.

Sincerely,

Steven H. Schouweiler
EVP & COO
Standard Life and Accident Insurance Company